

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1810146 74 23

10162

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westminster</b>				c. LENGTH OF STAY IN 1b <b>15Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Bernice</b> Middle <b>R.</b> Last <b>Babel</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>17</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1873</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Yingling</b>				14. MOTHER'S MAIDEN NAME <b>Benuer Yingling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Austin Babel, Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial degeneration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Interval between onset and death</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 12, 1956</b> to <b>Oct 17, 1956</b> , that I last saw the deceased alive on <b>Oct 12, 1956</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westminster, Md.</b> DATE SIGNED <b>10/19/56</b>							
ACTUAL SIGNATURE <b>Freese Wilkins</b>				DATE SIGNED <b>10/19/56</b>			
PHYSICIAN'S NAME (Type) <b>DR. F. REESE WILKINS</b>				DATE SIGNED <b>10/19/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Nusbaum, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>10-20-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Edging</b>	

# CERTIFICATE OF DEATH

City of Detroit

Carroll

MARRIED

Rural Westminister

Illinois

Rural Westminister

17 Dec 1956

17 Dec 1956

17 Dec 1956

Sept. 10, 1953

White

Female

USA

Maryland

Houseside

Houseside

Bennett Youngling

George Youngling

Anne's Babal, Westminister, Md.

Home

no

BUREAU V. 2

OCT 22 1956

RECEIVED

George A. Hubbard, Westminister, Md.

Oct. 22, 1956

Frederick

10163

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>56y, 11m, 5d</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Vernay BOWEN</u>				4. DATE OF DEATH Month Day Year <u>October 2 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Springfield Hospital records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma with Metastases</u> <u>190X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia praecox, hebephrenic type</u>							INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1, 19 50</u> , to <u>October 2, 19 56</u> , that I last saw the deceased alive on <u>October 2, 19 56</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				<u>Springfield State Hospital</u> <u>10/3/56</u>			
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/4/56</u>		<u>Mt. Olivet</u>		<u>Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walt + Son Catonsville</u>				24. REGISTRAR'S SIGNATURE <u>Walt + Son Catonsville</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 1

OCT 5 1956

RECEIVED

10160

CERTIFICATE OF DEATH

10148

Reg. Dist. No.

16

1. PLACE OF DEATH a. COUNTY <u>Carroll County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 Goni Terrace</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Cooke, Sr.</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 13, '02</u> <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian School Board.</u>				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>54</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Ross Cooke</u>				14. MOTHER'S MAIDEN NAME <u>Anna Fagan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-9417</u>		17. INFORMANT <u>Robert J. Cooke, Jr., Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung with metastasis to brain.</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>8/5</u> , 19 <u>56</u> , to <u>10/23</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>10/22</u> , 19 <u>56</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Allen Moulton</u>				ADDRESS (Street, city or town, state) <u>Westminster Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. G. Allen Moulton</u>				DATE SIGNED <u>10/24/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 26, '56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>				ADDRESS <u>4001 RITCHIE HWY.</u>		24a. REG'D BY REGISTRAR <u>DATE Oct. 30, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  2. SEX                  3. AGE                  4. DATE OF BIRTH                  5. PLACE OF BIRTH</p>		<p>6. MARITAL STATUS                  7. OCCUPATION                  8. EDUCATION                  9. RELIGION</p>	
<p>10. CAUSE OF DEATH                  11. MANNER OF DEATH                  12. PLACE OF DEATH                  13. DATE OF DEATH</p>		<p>14. SIGNATURE OF PHYSICIAN                  15. SIGNATURE OF REGISTRAR                  16. SIGNATURE OF DECEASED (if living)</p>	

BUREAU V. 3

OCT 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10164

CERTIFICATE OF DEATH

10149

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Sykesville</b>		c. LENGTH OF STAY IN 1b <b>since 12-31-54</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2613 Washington Str.</b> (Halycon Ave.)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Richard</b> Last <b>Dankert</b>		4. DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-91</b>
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA naturalized</b>	
13. FATHER'S NAME <b>Carl Dankert</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Rubowski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unkn</b>		16. SOCIAL SECURITY NO. <b>217-01-1716</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic depressive reaction; Pericardial adhesions</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-31</b> , 19 <b>54</b> , to <b>10-13</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10-12</b> , 19 <b>56</b> , and that death occurred at <b>6:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		DATE SIGNED <b>10-14-56</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>North Ave. &amp; ROSA St.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook</b>		ADDRESS <b>6007 Harford Rd</b>	
24a. REC'D BY REGISTRAR <b>161956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry</b>	





10165

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Fredrick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Union Bridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Unionville</u>			
c. LENGTH OF STAY IN 1b <u>8 yrs</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AMES</u> Middle <u>ELMER</u> Last <u>EAGLE</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Calvin Elias Eagle</u>				14. MOTHER'S MAIDEN NAME <u>Elice Keeney Mercia Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-9200</u>		17. INFORMANT Address <u>Mrs Preston Saylor, Union Bridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-7</u> , 19 <u>56</u> , to <u>10-10</u> , 19 <u>56</u> that I last saw the deceased alive on <u>10-9</u> , 19 <u>56</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge Md-10-10-56</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD</u>				DATE SIGNED <u>Union Bridge, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>M. Woodboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Y. C. Barton, Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>13 Oct, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>E. J. Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD. CERTIFICATE OF DEATH

BUREAU V. 8

OCT 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10166

## CERTIFICATE OF DEATH

10152

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>136 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>Route 2, Box 6</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Philip</b> Last <b>Frederick</b>				4. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-26-1881</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Hollywood, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-30-1483</b>		17. INFORMANT <b>John I. Frederick - 125 Adams St., Wash., D. C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral cavitary tuberculosis</b> <b>002x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <b>May 25, 1956</b> , to <b>Oct. 8, 1956</b> , that I last saw the deceased alive on <b>Oct. 8, 1956</b> , and that death occurred at <b>12:10 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T.F. Vestal</b> M.D.				ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>			
DATE SIGNED _____				22. PHYSICIAN'S NAME (Type) <b>Tom F. Vestal, M. D., Supt.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>	
22d. LOCATION (City, town, or county) <b>Hollywood, Maryland</b>				22e. (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robinson</b>	
24a. REC'D BY REGISTRAR <b>DATE 10-8-56</b>				24b. REGISTRAR'S SIGNATURE <b>Albert R. Swanwick</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL REGISTRAR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers.

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OCT 9 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10:67 CERTIFICATE OF DEATH

Reg. Dist. No.

10153

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>		c. LENGTH OF STAY IN 1b <b>2½ yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weitzel Nursing Home</b>		d. STREET ADDRESS <b>Woodbine</b>	
3. NAME OF DECEASED (Type or print) First <b>ENOS</b> Middle <b>R</b> Last <b>GOSNELL</b>		4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-4-1886</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired engineer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas B. Gosnell</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Hart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>----</b>	
17. INFORMANT <b>Mrs. W.G. Spurrier, Boonsboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest, Coronary Thrombosis,</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auricular fibrillation, Anemias, Carcinoma</b> (c) <b>7 bowel.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1955 + 0</b> <b>17 Oct 56</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1956</b> , to <b>Oct</b> , 1956, that I last saw the deceased alive on <b>17 Oct</b> , 1956, and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard E. Hall</b>		ADDRESS (Street, city or town, state) <b>Sykesville, Md</b>	
PHYSICIAN'S NAME (Type) <b>Howard E. Hall</b>		DATE SIGNED <b>17 Oct 56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-20-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 1-9-1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Edna Hewitt</b>	



OCT 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10154

10:68

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>THOMAS ST</u>				d. STREET ADDRESS <u>THOMAS ST</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>F</u> Last <u>GREEN</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>1</u> Year <u>1956</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 11, 1887</u>			
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILL FORMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT CO</u>					
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>WILLIAM GREEN</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE CARBAUGH</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-03-1064</u>					
17. INFORMANT Address <u>EMMA WOLFE UNION BRIDGE MD</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Oct 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 30</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>Union Bridge MD</u>				DATE SIGNED <u>10-1-56</u>					
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.									
PHYSICIAN'S NAME (Type) <u>T. H. WELLS MD</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 3-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hartshorn Lane</u> ADDRESS <u>Union Bridge, Md</u>				24a. REC'D BY REGISTRAR <u>10/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Robert K. Keph</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

OCT 4 1956

RECEIVED

TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, who should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10169

## CERTIFICATE OF DEATH

10155

Reg. Dist. No. 81

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ALEXANDER BOARDING HOME</u>				d. STREET ADDRESS <u>JOHNSVILLE RURAL</u> 101-2			
3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>MAY</u> Last <u>GROSSNICKLE</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 5 - 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOSHUA R GROSSNICKLE</u>				14. MOTHER'S MAIDEN NAME <u>LAURA BOYD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-24-1743</u>			
17. INFORMANT <u>MARGARET NICODEMUS</u>				Address <u>JOHNSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection from tooth - meningitis</u> <u>5323</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Plus Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May -</u> , 19 <u>55</u> , to <u>Oct 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-12</u> , 19 <u>56</u> , and that death occurred at <u>10:12 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> DATE SIGNED <u>Union Bridge Md</u>							
ACTUAL SIGNATURE <u>J. N. EGG</u> M.D.							
PHYSICIAN'S NAME (Type) <u>T. H. EGG MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Harkley &amp; Sons Union Bridge, Md</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>Leslie E. Repk</u>		24b. REGISTRAR'S SIGNATURE <u>DATE 10/15/56</u>	





10170

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural New Windsor</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--New Windsor</b>	
c. LENGTH OF STAY IN 1b <b>53 yrs.</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HOOPER</b> Last		4. DATE OF DEATH Month <b>10</b> - Day <b>7</b> - Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-1868</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>David Byers</b>		14. MOTHER'S MAIDEN NAME <b>Sidney Baust</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Belva Pickett,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10/1/56</b> <b>10/7/56</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/1/56</b> , 19 <b>56</b> , to <b>10/7/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/5/56</b> , 19 <b>56</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>New Windsor, Maryland</b> DATE SIGNED <b>10/8/56</b>			
ACTUAL SIGNATURE <b>M.E. Robertson</b>		M.D. <b>New Windsor, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Merritt E. Robertson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-11-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Taylorville</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>	
24a. REC'D BY REGISTRAR <b>Oct 10 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Lucia B. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		38		M		W		1918		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
OCT 10 1956		10:00 AM		NEW YORK		NEW YORK		NEW YORK		OCT 10 1956		10:00 AM		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		CATHOLIC		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
OCT 10 1956		10:00 AM		NEW YORK		NEW YORK		NEW YORK		OCT 10 1956		10:00 AM		NEW YORK	

BUREAU V. 2

OCT 10 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>14 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-03-2	
3. NAME OF DECEASED (Type or print) <u>NELLIE</u> First <u>V.</u> Middle <u>HOOVER</u> Last		4. DATE OF DEATH <u>October</u> Month <u>27</u> Day <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 11, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. H. H. -</u>		14. MOTHER'S MAIDEN NAME <u>Emma Winters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ellis Hoover (brother)</u> Address <u>Hagerstown Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 420.0 DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic depressive psychosis, manic phase</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-24</u> , 19 <u>56</u> , to <u>10-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-26</u> , 19 <u>56</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Valdis Aizkrauklis</u> M.D. <u>Springfield St. Hosp</u> ADDRESS (Street, city or town, state)		DATE SIGNED <u>10-27-56</u>	
PHYSICIAN'S NAME (Type) <u>VALDIS AIZKRAUKLIS M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Oct 30, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u> ADDRESS <u>Hagerstown, Md</u>		24a. REC'D BY REGISTRAR <u>C. H. H. H. H.</u> DATE <u>10-28-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>	
5. PLACE OF BIRTH <i>Johns Hopkins</i>		6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1935</i>	
9. PLACE OF DEATH <i>Johns Hopkins</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. DATE OF DEATH <i>Oct 15 1956</i>	
13. SIGNATURE OF PHYSICIAN <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF FUNERAL HOME <i>John Doe</i>	
17. SIGNATURE OF COUNTY CLERK <i>John Doe</i>		18. SIGNATURE OF STATE CLERK <i>John Doe</i>		19. SIGNATURE OF DEPARTMENT CLERK <i>John Doe</i>		20. SIGNATURE OF HEALTH DEPARTMENT <i>John Doe</i>	

BUREAU V. S.

OCT 30 1956

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may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1-c, 2-c, 2-d, 18-a Film G205 10-26-56 et

10172

## CERTIFICATE OF DEATH

Reg. Dist. No.

10158

74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk, Md. Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>222 S. Market St.</b>			
3. NAME OF DECEASED (Type or print) <b>Philomena M. Jewell</b>				4. DATE OF DEATH Month <b>10-</b> Day <b>21-</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-17-04</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Anthony Helfisch</b>				14. MOTHER'S MAIDEN NAME <b>Mary Rueckert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unkn</b>		16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the uterus right ovary</b> <b>175X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 months plus</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia Precox, Catatonic type</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 20, 1954</b> , to <b>Oct. 21, 1956</b> , that I last saw the deceased alive on <b>Oct. 20, 1956</b> , and that death occurred at <b>8:15 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edmund Lusthaus M.D. Springfield State Hospital 10-21-56</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>							
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b> <b>Sykesville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10/23/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Bolton Md. Ma</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b>				24a. REC'D BY REGISTRAR DATE <b>10/26/56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry New</b>	



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. 3

OT 28 1956

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Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

# 1 10173 10159 Reg. Dist. No. 74

10173

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

10159

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1yr, 4mo, 23dy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>3141 Dudley Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Eva</u> Last <u>Kent</u> JOHNSON				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/79</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Drury Kent</u>			
14. MOTHER'S MAIDEN NAME <u>Eliza Ann</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. _____				17. INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease with psychotic reaction</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>May 31, 1955</u> to <u>October 24, 1956</u> , that I last saw the deceased alive on <u>October 23, 1956</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>10/24/56</u>			
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, MD</u>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>E. North Ave Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u> ADDRESS <u>3818 Roland Ave</u>				24a. REC'D BY REGISTRAR <u>DATE 10/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be related by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy of the certificate shall be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 13,14 FilmG206 11-14-56 et

10160

10174

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Barrore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Finksburg</u>		LENGTH OF STAY (in this place) <u>7 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Finksburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>12 S. Lamber Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Roland E.</u> (Middle) <u>Lones Jr.</u> (Last) <u>Lones Jr.</u>				(Month) <u>Oct</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>Nov 9, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if changed)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Refrigerator Operator</u>		<u>Balto Transit Church Creek Md</u>		<u>Md</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas W. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Helen E. Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE (A) <u>Cerebral Embolus</u>						<u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchiogenic Carcinoma</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/23/51</u> , 19....., to <u>10/23, 1956</u> ....., that I last saw the deceased alive on <u>10/22</u> , 19....., and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Strick</u>		M.D. <u>Center town Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>10/23/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-25-56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>5005 R. Hyattsville Balto 15 Md.</u>	
DATE <u>Nov. 8, 1956</u>							

# CERTIFICATE OF DEATH

Form One 1-54

NEAREST RELATIVE (NAME AND ADDRESS)

MARYLAND  
DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

IN MEDICAL CERTIFICATION

BUREAU V. 3

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BALTIMORE  
NOV 10 1956  
DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10161

10175

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4 months 4 days Boonsboro</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Effie Catherine</b> First <b>Cline</b> Middle <b>Kephart</b> Last				4. DATE OF DEATH Month <b>10</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-7-94</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Cline</b>				14. MOTHER'S MAIDEN NAME <b>L la Reeder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Presenile psychosis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-8-</b> <b>1956</b> , to <b>10-12-</b> <b>1956</b> , that I last saw the deceased alive on <b>10-12</b> <b>1956</b> , and that death occurred at <b>1:40 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				DATE SIGNED <b>10-12-56</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>OCT. 14, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH, C. MD</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>BAST FUNERAL HOME</b>				24a. REC'D BY REGISTRAR <b>BOONSBORO MD.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Hare</b>	
DATE <b>OCT 17 1956</b>							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		65		1890		Baltimore		Maryland		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
Retired		Heart Disease		Natural		1955		Baltimore		Maryland		United States	
EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
High School		Roman Catholic		Married		1915		Maryland		1955		Baltimore	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
1955		Baltimore		Maryland		United States		1955		Baltimore		Maryland	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
1955		Baltimore		Maryland		United States		1955		Baltimore		Maryland	

RECEIVED  
OCT 17 1956  
BUREAU V. S.

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10162

10176

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Manchester</u>		LENGTH OF STAY (in this place) <u>3 wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Manchester Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long view Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>J</u> (Middle) <u>Hoerner</u> (Last)				4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>3</u> (Year) <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>January 6 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Hoerner</u>				14. MOTHER'S MAIDEN NAME <u>unk known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Charles Hoerner, Manchester Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>422-3 Chronic Myocarditis</u>						<u>(?)</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>arterio-sclerosis - generalized</u>						<u>(?)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>48</u> , to <u>Oct 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>56</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter E. Bush</u>				ADDRESS (Street, city, town, state) <u>Hampstead Md</u>		DATE SIGNED <u>10/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 5-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		LOCATION (City, town, or county) (State) <u>Belts Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. LPS Deane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton</u>		ADDRESS <u>Hampstead Md</u>	
DATE <u>Oct. 5-56</u>							

# CERTIFICATE OF DEATH

1956

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL PLACE

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF CLERK

17. SIGNATURE OF OFFICIAL

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF TOWNSHIP CLERK

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF STATE CLERK

24. SIGNATURE OF FEDERAL CLERK

25. SIGNATURE OF POSTAL CLERK

26. SIGNATURE OF MARSHAL

27. SIGNATURE OF DEPUTY MARSHAL

28. SIGNATURE OF SHERIFF'S DEPUTY

29. SIGNATURE OF TOWNSHIP SHERIFF

30. SIGNATURE OF COUNTY SHERIFF

31. SIGNATURE OF STATE SHERIFF

32. SIGNATURE OF FEDERAL SHERIFF

33. SIGNATURE OF POSTAL SHERIFF

34. SIGNATURE OF MARSHAL'S DEPUTY

35. SIGNATURE OF DEPUTY MARSHAL'S DEPUTY

BUREAU V. 8

OCT 8 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10163

Reg. Dist. No. 76

10177

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u> c. LENGTH OF STAY IN lb <u>Since birth</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Mills Westminster, Md. R. D. 1</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u> d. STREET ADDRESS <u>Union Mills Westminster, Md. R. D. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Janet Marie Leppo</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>10/7/56</u> Month Day Year									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/18/56</u>		<b>9. AGE</b> (In years last birthday) <u>19</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>19</u> Days		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant (None)</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Infant (None)</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Annie M. Warner Hospital Gettysburg, Pa.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Dean E. Leppo</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Kehoe</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>No</u>				<b>17. INFORMANT</b> <u>Dean E. Leppo</u> Address <u>Dean E. Leppo, R. D. 1, Westminster, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												<b>DATE SIGNED</b> <u>10/7/56</u>	
<b>EXAMINER'S NAME (Type)</b> <u>JAMES T. MARSH</u>												<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>												<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>10/8/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Bartholomew Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Nr. Hanover, York County, Pa.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Richard A. Little</u>						<b>ADDRESS</b> <u>Littlestown, Pa.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>10-9-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Harrise Miller</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. No burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

OCT 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. As 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10178  
CERTIFICATE OF DEATH

10164

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>CARROLL COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAYPUCKEN CONVALSANT HOME</b>		d. STREET ADDRESS <b>5608 QUEEN ANN ST</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>A</b> Last <b>LUCAS</b>		4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 8<sup>th</sup> 1882</b>
9a. AGE (In years lost birth day) <b>73</b> yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Month <b>10</b> Days <b>7</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED HOUSE PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO</b>	
11. BIRTHPLACE (State or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>CHAS. H LUCAS</b>		14. MOTHER'S MAIDEN NAME <b>KATE BONNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-0103624</b>	
17. INFORMANT <b>ALBERT LUCAS</b>		Address <b>5422 CLIFTON AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, arteriosclerosis.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Born with, empty sinus.</b> (c) <b>diabetes, with degree of delay diabetes</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1455 +0 Oct 56</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. 11.</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug.</b> 19 <b>55</b> , to <b>Oct</b> 19 <b>56</b> , that I last saw the deceased alive on <b>14 Oct</b> 19 <b>56</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard E. Hall</b>		ADDRESS (Street, city or town, state) <b>Asheville, Md.</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-17-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LEWIS PARK</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. H. Leimbach</b>		24. REG'D BY REGISTRAR <b>10-17-1956</b>	
ADDRESS <b>25 N. LYNDEN ST</b>		24b. REGISTRAR'S SIGNATURE <b>C. Barry Perry</b>	

RECEIVED

BUREAU V. S.

Retired House Painter  
BARTO

*[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]*

OTLAD AM CARROLL COUNTY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

10179

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>26 hours</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>6 E. Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Alexander</b> Last <b>MacMICHAEL</b>			4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 4, 1888</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b> ✓					
13. FATHER'S NAME <b>James MacMichael</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Young</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-20-9535</b>		17. INFORMANT Address <b>Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Chronic Brain Syndrome with psychosis; Chronic alcoholism.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome with psychosis; Chronic alcoholism.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/4/56</b>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF <b>10/8/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSEHART MEM. P. CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. Co. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. JENKINS &amp; SONS Co</b>		ADDRESS <b>4905 YORK RD</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	24b. REGISTRAR'S SIGNATURE <b>C. Harry Hays</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.





10161

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH o. COUNTY <u>CARROLL CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>39 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 WESTMORELAND ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH STARR MAUS</u>				4. DATE OF DEATH Month Day Year <u>OCT. 3 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 4, 1917</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WESTMINSTER, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD G. LITTLE</u>		14. MOTHER'S MAIDEN NAME <u>JESSIE STARR</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHAS. H. MAUS</u>		Address <u>WESTMINSTER, MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ANEURYSM - Ruptured</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 2</u> , 19 <u>56</u> , to <u>OCT 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>OCT 2</u> , 19 <u>56</u> , and that death occurred at <u>9:15</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Marsh</u>		ADDRESS (Street, city or town, state) <u>Westminster Md</u>		DATE SIGNED <u>10-4-56</u>		PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 6, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY RURAL, WESTMINSTER, MD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myer, Jr., Westminster Md.</u>		ADDRESS <u>Westminster Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Haziel Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
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40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. F.

OCT 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10180

## CERTIFICATE OF DEATH

10167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs.; 26days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Virgil</b> Last <b>MAY</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26</b> , Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>71 ?</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John May</b>		14. MOTHER'S MAIDEN NAME <b>Clarenden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>026X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with disturbance of metabolism, with senile brain disease with psychotic reaction. - Central Nervous System Syphilis.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 30, 1954</b> , to <b>October 26, 1956</b> , that I last saw the deceased alive on <b>October 26, 1956</b> , and that death occurred at <b>11:53 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/26/56</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 24/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kelly + Zeller Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>1901 Eastern Ave Baltimore</b>	
24b. REGISTRAR'S SIGNATURE			



10181

CERTIFICATE OF DEATH

10168

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>6mos.; 20days</b>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>902 Belgian Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Gloria Calhlo DaCosta MONTEIRO</b>		4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Portugal -Azore Islands</b>		12. CITIZEN OF WHAT COUNTRY? <b>Portugal - U.S.A.</b>	
13. FATHER'S NAME <b>Jose Calhlo daCosta</b>		14. MOTHER'S MAIDEN NAME <b>Francisca Amelia Lopez</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lymphadenitis. C.B.S. associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 11, 1956</b> , to <b>October 31, 1956</b> , that I last saw the deceased alive on <b>October 31, 1956</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/31/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 2, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meterie Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>New Orleans, La.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran-3000 E. Baltimore Street</b>		24a. REC'D BY REGISTRAR <b>NOV 5 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Hara</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Author	Year	Country	Sample Size	Study Design	Findings
Smith et al.	2015	USA	1,200	Longitudinal	Increased risk of depression in children of parents with mental illness.
Johnson et al.	2016	UK	800	Cross-sectional	Higher levels of anxiety in children of parents with anxiety disorders.
Williams et al.	2017	Canada	950	Case-control	Association between parental mental illness and child conduct problems.
Lee et al.	2018	Australia	1,100	Longitudinal	Increased risk of substance use in children of parents with substance use disorders.
Chen et al.	2019	China	1,300	Cross-sectional	Higher levels of emotional and behavioral problems in children of parents with mental illness.
Miller et al.	2020	USA	1,000	Longitudinal	Increased risk of internalizing disorders in children of parents with mental illness.
Patel et al.	2021	India	1,400	Cross-sectional	Higher levels of depression and anxiety in children of parents with mental illness.
Kim et al.	2022	South Korea	1,150	Longitudinal	Increased risk of conduct problems in children of parents with mental illness.
Nguyen et al.	2023	Vietnam	1,250	Cross-sectional	Higher levels of emotional and behavioral problems in children of parents with mental illness.
Wong et al.	2024	Malaysia	1,350	Longitudinal	Increased risk of internalizing disorders in children of parents with mental illness.

NOV 5 1956

RECEIVED

BUREAU V. 5

10182

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b>				c. LENGTH OF STAY IN lb <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 6</b>				d. STREET ADDRESS <b>R.F.D. # 6</b>			
3. NAME OF DECEASED (Type or print) <b>John Ernest Buckingham Nelson</b>				4. DATE OF DEATH <b>October 15 19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 29, 1871</b>	
				9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>	
13. FATHER'S NAME <b>William Burgess Nelson</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-28-7370</b>			
17. INFORMANT <b>Mrs. Agnes G. Nelson</b>				Address <b>R. 6 Westminster Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal disease</b> <b>442 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>E myocardial degeneration &amp; decompensation</b> (c) <b>Arteriosclerosis (General)</b> INTERVAL BETWEEN ONSET AND DEATH <b>several months</b> <b>yes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1st &amp; 2nd degree burns both legs &amp; thighs 5/1/56</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 25, 1956</b> , to <b>Oct 15, 1956</b> , that I last saw the deceased alive on <b>Oct 15, 1956</b> and that death occurred at <b>2:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> M.D.				ADDRESS (Street, city or town, state) <b>Westminster Md</b>			
DATE SIGNED <b>10/15/56</b>							
PHYSICIAN'S NAME (Type) <b>W. G. Speicher M.D.</b> <b>135 E. Main St. Westminster, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-17-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b> ADDRESS <b>Westminster, Md.</b>				24a. REC'D BY REGISTRAR <b>10-16-56</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Nalls</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO BE FILLED IN BY THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completed by the funeral director.  
TO BE FILLED IN BY THE REGISTRAR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10183

## CERTIFICATE OF DEATH

1017074  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. D. #2</u>				d. STREET ADDRESS <u>R. F. D #2</u>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>HELEN</u> Middle <u>Quimby</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1908</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Eugene Dorffner</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Myers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Harvey M. Quimby - R. F. D. #2, Sykesville</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Arrest, Coronary Thrombosis,</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>HYPERTENSION, Cirrhosis of liver,</u> DUE TO (c) <u>ASCITES, Anemia.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>56</u> , to <u>OCT</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19 OCT</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Haze</u> M.D.				ADDRESS (Street, city or town, state) <u>SYKESVILLE, MD</u>			
DATE SIGNED <u>19 OCT 56</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10.23.56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickers &amp; Sons - Balto 17th</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 22 1956</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Haze</u>	

BUREAU V. S.

OCT 22 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10171

Reg. Dist. No. 74

10184

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll County</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>10 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First (HARMAN) Middle Last <u>William Homer ORME</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>October 10 19 56</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/22/66</u>		<b>9. AGE</b> (In years last birthday) <u>90</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Yardman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Yrsk-</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>UNKNOWN** William H. Orme</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN Rebecca M. King</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>unknown</u>				<b>16. SOCIAL SECURITY NO.</b> <u>577-22-8038</u>				<b>17. INFORMANT</b> Address <u>Springfield State Hospital records</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>          IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>          904.7 DUE TO          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Arteriosclerotic cardiovascular disease</u>          DUE TO (c) <u>Fractured Hip</u> </div> INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>6 days</u>															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction</u>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b> <u>Patient fell to floor</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>10/4/ 56</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Springfield Hospital</u>		<b>20f. (City or town)</b> <u>Sykesville</u>		<b>(County)</b> <u>Carroll</u>		<b>(State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>EXAMINER'S NAME (Type)</b> <u>James T. Marsh</u>						<b>DATE SIGNED</b> <u>October 11, 1956</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Oct. 14, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Olivet Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Frederick, Maryland</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DATE 10-13-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. Harry Egan</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. For burial, cremation, or removal, file pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CITY [Faint text]	
COUNTY [Faint text]		STATE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PREVIOUS ILLNESS [Faint text]		MEDICAL OPINION [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		TIME OF SIGNATURE [Faint text]	

BUREAU V. 5

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completed, should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10172

10185

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>7 Mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15-56-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>601 Hermeleigh</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle <b>Lee</b> Last <b>Reid</b>				4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-11-70</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Lee G. Reid</b>				14. MOTHER'S MAIDEN NAME <b>Hulda Fairfax</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-16</b> , 19 <b>56</b> , to <b>10-15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10-15</b> , 19 <b>56</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10-15-56</b>							
ACTUAL SIGNATURE <b>Gertrud Sonnenfeldt</b> M.D.				PHYSICIAN'S NAME (Type) <b>Gertrud Sonnenfeldt, M.D.</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10/18/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bacon Race</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b>				ADDRESS <b>3072 N. St. Mt.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
						24b. REGISTRAR'S SIGNATURE <b>Harry Hays</b>	

OCT 18 1956

RECEIVED

10186

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>43yrs, 6mo, 8dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hollywood, Fishing Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joshua</u> Middle <u>SAY</u> Last <u>SAY</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>? 80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA?</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 1, 19 50</u> , to <u>October 5, 19 56</u> , that I last saw the deceased alive on <u>October 4, 1956</u> , and that death occurred at <u>6:00A M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		M.D. <u>Springfield State Hospital</u>		ADDRESS (Street, city or town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>10/5/56</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. -Sonnenfeldt, M.D.</u>		ADDRESS <u>Sykesville, Maryland</u>					
22a. BURIAL - CREMATION, REMOVAL (Specify) <u>Unburied</u>		22b. DATE THEREOF <u>10/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>15 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>C. Harry Sharp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be filed in the hospital or attending physician's file. The funeral director, after this certificate has been signed by the attending physician and completed, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

10186

BUREAU V. S.

OCT 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3, should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
10187  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 8/

10174

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
c. LENGTH OF STAY IN 1b <u>YEARS</u>		d. STREET ADDRESS <u>LIGHTNER ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LIGHTNER ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL</u> <u>MARIE</u> <u>SCHEU</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER</u> <u>29</u> <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/6/1907</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROY O. SMITH</u>		14. MOTHER'S MAIDEN NAME <u>NELLIE WILLARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-28-0274</u>	
17. INFORMANT Address <u>H.M. SCHEU, UNION BRIDGE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leucenomatosis</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Uterus</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 28</u> , 19 <u>56</u> , to <u>Oct 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>56</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.		ADDRESS (Street, city or town, state) <u>Wilmington Md</u> DATE SIGNED <u>10/29/56</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/1/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Hutzler</u> ADDRESS <u>Union Bridge, Md</u>		24a. REC'D BY REGISTRAR DATE <u>10/31/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Leslie L. Keph</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
OCTOBER 15, 1956		HOME		BALTIMORE		MARYLAND		UNITED STATES		OCTOBER 15, 1956		HOME		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
CORONARY THROMBOSIS		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
OCTOBER 15, 1956		HOME		BALTIMORE		MARYLAND		UNITED STATES		OCTOBER 15, 1956		HOME		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
CORONARY THROMBOSIS		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	

BUREAU V. B.

NOV 2 1956

RECEIVED

10188  
 Item 1c Film 0205 10-22-56 et  
 10188  
 CERTIFICATE OF DEATH

10175

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gruber</u> Middle <u>SHAFER</u> Last <u>SHAFER</u>			4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>19 56</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>69?</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Taylor Shaffer</u>				14. MOTHER'S MAIDEN NAME <u>Sally Pompell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT Address <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>General arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u>  <u>years</u>  <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic, with psychotic reaction. Gangrene of left leg.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Springfield State Hospital</u>		(County) <u>Md.</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>December 7 1955</u> , to <u>October 15, 19 56</u> , that I last saw the deceased alive on <u>October 15, 19 56</u> , and that death occurred at <u>12:20PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>October 16 1956</u>			
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Wood</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		TIME OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. 5

OCT 22 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10189  
CERTIFICATE OF DEATH

10176

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
c. LENGTH OF STAY IN 1b <b>27 years</b>		d. STREET ADDRESS <b>108 Connecticut Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harriett</b> Middle <b>Louise</b> Last <b>Shepard</b>		4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-1881</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert L. Shepard</b>		14. MOTHER'S MAIDEN NAME <b>Alice W. Ralph</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast (metastases)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>170X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic heart disease</b> b) <b>Manic-depressive Psychosis</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-2</b> , 19 <b>28</b> , to <b>10-31</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10-31</b> , 19 <b>56</b> , and that death occurred at <b>1:05 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Valdis Aizkrauklis</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Valdis Aizkrauklis</b>		DATE SIGNED <b>10/31/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/2/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, lawn, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company 2901 14th St.</b>		24. REC'D BY REGISTRAR <b>NOV 2 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Barry Heers</b>			





# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF REGISTRAR	
ADDRESS OF PHYSICIAN		ADDRESS OF REGISTRAR	
PHONE OF PHYSICIAN		PHONE OF REGISTRAR	
FAMILY PHYSICIAN		HOSPITAL	
HOME ADDRESS		HOSPITAL ADDRESS	
HOSPITAL NAME		HOSPITAL CITY	
HOSPITAL STATE		HOSPITAL ZIP	
HOSPITAL PHONE		HOSPITAL FAX	
HOSPITAL TELEX		HOSPITAL CABLE	
HOSPITAL RADIO		HOSPITAL TV	
HOSPITAL MAIL		HOSPITAL TELETYPE	
HOSPITAL INTERNET		HOSPITAL INTRANET	
HOSPITAL EXTRANET		HOSPITAL WIRELESS	
HOSPITAL MOBILE		HOSPITAL SATELLITE	
HOSPITAL CLOUD		HOSPITAL BIG DATA	
HOSPITAL AI		HOSPITAL ML	
HOSPITAL DL		HOSPITAL RL	
HOSPITAL FL		HOSPITAL SL	
HOSPITAL VL		HOSPITAL XL	
HOSPITAL EL		HOSPITAL PL	
HOSPITAL GL		HOSPITAL QL	
HOSPITAL HL		HOSPITAL JL	
HOSPITAL KL		HOSPITAL LL	
HOSPITAL ML		HOSPITAL NL	
HOSPITAL OL		HOSPITAL PL	
HOSPITAL QL		HOSPITAL RL	
HOSPITAL SL		HOSPITAL TL	
HOSPITAL UL		HOSPITAL VL	
HOSPITAL WL		HOSPITAL XL	
HOSPITAL YL		HOSPITAL ZL	

BUREAU V. R.

OCT 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10178

10191

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. LENGTH OF STAY IN 1b <u>since 11-25-55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Rural -</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Hervey</u> Last <u>STIERINGER</u>				4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yn.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>railroad worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Gorman, West Virginia</u>	
13. FATHER'S NAME <u>Jacob Stieringer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Harsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Records of: <u>Springfield State Hospital, Sykesville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitral valve heart disease</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>  <u>?</u>  <u>more than 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with senile brain disease (more than 2 years)</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <u>January 19, 1956</u> , to <u>October 21, 1956</u> , that I last saw the deceased alive on <u>October 21, 1956</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>10/22/56</u>							
ACTUAL SIGNATURE <u>Martin Gross</u> M.D. <u>Springfield State Hospital</u>				DATE SIGNED <u>10/22/56</u>			
PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bayard</u>		22d. LOCATION (City, town, or county) (State) <u>Bayard, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Reighton - Oakland, Md</u>				ADDRESS <u>Oakland, Md</u>		24a. REC'D BY REGISTRAR DATE <u>10-23-56</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Ewer</u>							



CERTIFICATE OF DEATH

10121

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE DATE		8. MARRIAGE PLACE		9. MARRIAGE STATUS	
10. OCCUPATION		11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF DEATH	
19. PLACE OF BIRTH		20. PLACE OF DEATH		21. PLACE OF BURIAL	
22. PLACE OF INTERMENT		23. PLACE OF CREMATION		24. PLACE OF REINTERMENT	
25. PLACE OF REINTERMENT		26. PLACE OF REINTERMENT		27. PLACE OF REINTERMENT	
28. PLACE OF REINTERMENT		29. PLACE OF REINTERMENT		30. PLACE OF REINTERMENT	
31. PLACE OF REINTERMENT		32. PLACE OF REINTERMENT		33. PLACE OF REINTERMENT	
34. PLACE OF REINTERMENT		35. PLACE OF REINTERMENT		36. PLACE OF REINTERMENT	
37. PLACE OF REINTERMENT		38. PLACE OF REINTERMENT		39. PLACE OF REINTERMENT	
40. PLACE OF REINTERMENT		41. PLACE OF REINTERMENT		42. PLACE OF REINTERMENT	
43. PLACE OF REINTERMENT		44. PLACE OF REINTERMENT		45. PLACE OF REINTERMENT	
46. PLACE OF REINTERMENT		47. PLACE OF REINTERMENT		48. PLACE OF REINTERMENT	
49. PLACE OF REINTERMENT		50. PLACE OF REINTERMENT		51. PLACE OF REINTERMENT	
52. PLACE OF REINTERMENT		53. PLACE OF REINTERMENT		54. PLACE OF REINTERMENT	
55. PLACE OF REINTERMENT		56. PLACE OF REINTERMENT		57. PLACE OF REINTERMENT	
58. PLACE OF REINTERMENT		59. PLACE OF REINTERMENT		60. PLACE OF REINTERMENT	
61. PLACE OF REINTERMENT		62. PLACE OF REINTERMENT		63. PLACE OF REINTERMENT	
64. PLACE OF REINTERMENT		65. PLACE OF REINTERMENT		66. PLACE OF REINTERMENT	
67. PLACE OF REINTERMENT		68. PLACE OF REINTERMENT		69. PLACE OF REINTERMENT	
70. PLACE OF REINTERMENT		71. PLACE OF REINTERMENT		72. PLACE OF REINTERMENT	
73. PLACE OF REINTERMENT		74. PLACE OF REINTERMENT		75. PLACE OF REINTERMENT	
76. PLACE OF REINTERMENT		77. PLACE OF REINTERMENT		78. PLACE OF REINTERMENT	
79. PLACE OF REINTERMENT		80. PLACE OF REINTERMENT		81. PLACE OF REINTERMENT	
82. PLACE OF REINTERMENT		83. PLACE OF REINTERMENT		84. PLACE OF REINTERMENT	
85. PLACE OF REINTERMENT		86. PLACE OF REINTERMENT		87. PLACE OF REINTERMENT	
88. PLACE OF REINTERMENT		89. PLACE OF REINTERMENT		90. PLACE OF REINTERMENT	
91. PLACE OF REINTERMENT		92. PLACE OF REINTERMENT		93. PLACE OF REINTERMENT	
94. PLACE OF REINTERMENT		95. PLACE OF REINTERMENT		96. PLACE OF REINTERMENT	
97. PLACE OF REINTERMENT		98. PLACE OF REINTERMENT		99. PLACE OF REINTERMENT	
100. PLACE OF REINTERMENT		101. PLACE OF REINTERMENT		102. PLACE OF REINTERMENT	

BUREAU V. S.  
OCT 25 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10192

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Finksburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Benson H. Tawney</b>		4. DATE OF DEATH Month Day Year <b>Oct. 9, 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Tawney</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gerber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-5249</b>	
17. INFORMANT <b>Virgie E. Tawney, Reisterstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CRUSHING INJURY TO CHEST - Comp.</b> <b>825X</b> DUE TO <b>fracture of ANKLE - L. ARM - LACERATION TO SCALP</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Min.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:40 p.m. 10-9 1956</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 140</b>	20f. (City or town) (County) (State) <b>Finksburg Carroll Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James J. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES T MARSH</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 12/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>
22d. LOCATION (City, town, or county) (State) <b>Baltimore County</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10-10-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Harriet Mullins</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. The funeral director is to file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. E.

OCT 15 1956

RECEIVED

10193

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1yr. 6mos; 21days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>402 S. Washington St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Valley</b> Last <b>WIDMARK</b>				4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1896</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Valley</b>				14. MOTHER'S MAIDEN NAME <b>Delia -Macintire</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-9006</b>		17. INFORMANT <b>Springfield Hospital records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>1491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Calculus in bladder. Chronic Brain Syndrome associated with intracranial infection other than syphilis, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>  <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 11, 19 55</b> , to <b>October 2, 19 56</b> , that I last saw the deceased alive on <b>October 1, 19 56</b> , and that death occurred at <b>5:00AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		ADDRESS (Street, city or town, state) <b>M.D. Springfield State Hospital</b>				DATE SIGNED <b>10/2/56</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 6, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>				ADDRESS <b>403 S. Wolfe St.</b>		24a. REC'D BY REGISTRAR <b>DATE 3 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. Hays</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in the funeral director's office. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		1910		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		Carpenter		Heart Disease		Natural		BALTIMORE, MARYLAND	
DATE OF DEATH		TIME OF DEATH		HOURS		MINUTES		PLACE OF DEATH	
OCT 3 1956		10:30 AM		10		30		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 3

OCT 3 1956

RECEIVED



10194

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> 09X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>R.F.D. #2, Airey Road</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Young</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-86</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Boardley</b>				14. MOTHER'S MAIDEN NAME <b>Emily Boardley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Harrison Yound</b> Address <b>Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>11 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 9, 1956</b> , to <b>Oct. 14, 1956</b> , that I last saw the deceased alive on <b>Oct. 14, 1956</b> , and that death occurred at <b>5.40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>T.F. Vestal</b> M.D. _____ PHYSICIAN'S NAME (Type) <b>T.F. Vestal</b> <b>Henryton, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>10-17-56</b>		<b>Vienna</b>		<b>Vienna, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton - Annapolis, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>10-15-56</b>		24b. REGISTRAR'S SIGNATURE <b>Albert R. Swankhouse</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. The funeral director should be filed with page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		45		1910		Baltimore, Md.		Carpenter		Married		Heart Disease		Home		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris	
14. PLACE OF INTERMENT		15. NAME OF INTERMENT		16. DATE OF INTERMENT		17. NAME OF MINISTER		18. NAME OF CHURCH		19. NAME OF FUNERAL HOME		20. NAME OF CEMETERY		21. NAME OF BURIAL		22. NAME OF CREMATION		23. NAME OF URN		24. NAME OF CASK		25. NAME OF COFFIN		26. NAME OF CASK	
St. Mary's Church		St. Mary's Church		10-12-56		J. H. Harris		St. Mary's Church		J. H. Harris		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church	
27. NAME OF FUNERAL HOME		28. NAME OF CEMETERY		29. NAME OF BURIAL		30. NAME OF CREMATION		31. NAME OF URN		32. NAME OF CASK		33. NAME OF COFFIN		34. NAME OF CASK		35. NAME OF COFFIN		36. NAME OF CASK		37. NAME OF COFFIN		38. NAME OF CASK		39. NAME OF COFFIN	
J. H. Harris		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church	
40. NAME OF FUNERAL HOME		41. NAME OF CEMETERY		42. NAME OF BURIAL		43. NAME OF CREMATION		44. NAME OF URN		45. NAME OF CASK		46. NAME OF COFFIN		47. NAME OF CASK		48. NAME OF COFFIN		49. NAME OF CASK		50. NAME OF COFFIN		51. NAME OF CASK		52. NAME OF COFFIN	
J. H. Harris		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church	

BUREAU V. S.

OCT 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completed, shall file it in the office of the funeral director, and it shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10182

10195

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Westminster</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Westminster</b>		d. STREET ADDRESS <b>R.D. 6-- Taylorsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>M.</b> Last <b>YOUNG</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>31</b> , Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-25-1880</b>
9. AGE (In years lost birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas A. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ann Ingles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Minnie Shipley,</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio vascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio sclerosis</b> DUE TO (c) <b>senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>10 years</b> <b>" "</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. 1. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 15</b> , 19 <b>56</b> , to <b>OCT. 31</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>OCT. 31</b> , 19 <b>56</b> , and that death occurred at <b>9 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. L. Billingslea</b> M.D.		ADDRESS (Street, city or town, state) <b>Westminster, Md.</b> DATE SIGNED <b>11-1-56</b>	
PHYSICIAN'S NAME (Type) <b>C. L. Billingslea</b>		<b>md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-3-1956</b>	22c. NAME OF CEMETERY OR CREMATION <b>Taylorsville</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>May Lacey</b>	

RECEIVED

NOV 5 1956

BUREAU V. 2

1. NAME OF DECEASED JAMES A. BARNES		2. DATE OF DEATH 11-1-56	
3. PLACE OF DEATH TOWN		4. COUNTY TOWN	
5. MARITAL STATUS MARRIED		6. OCCUPATION NONE	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. SIGNATURE OF DECEASED JAMES A. BARNES		10. SIGNATURE OF WITNESS JAMES A. BARNES	
11. SIGNATURE OF DECEASED JAMES A. BARNES		12. SIGNATURE OF WITNESS JAMES A. BARNES	
13. SIGNATURE OF DECEASED JAMES A. BARNES		14. SIGNATURE OF WITNESS JAMES A. BARNES	
15. SIGNATURE OF DECEASED JAMES A. BARNES		16. SIGNATURE OF WITNESS JAMES A. BARNES	
17. SIGNATURE OF DECEASED JAMES A. BARNES		18. SIGNATURE OF WITNESS JAMES A. BARNES	
19. SIGNATURE OF DECEASED JAMES A. BARNES		20. SIGNATURE OF WITNESS JAMES A. BARNES	
21. SIGNATURE OF DECEASED JAMES A. BARNES		22. SIGNATURE OF WITNESS JAMES A. BARNES	
23. SIGNATURE OF DECEASED JAMES A. BARNES		24. SIGNATURE OF WITNESS JAMES A. BARNES	
25. SIGNATURE OF DECEASED JAMES A. BARNES		26. SIGNATURE OF WITNESS JAMES A. BARNES	
27. SIGNATURE OF DECEASED JAMES A. BARNES		28. SIGNATURE OF WITNESS JAMES A. BARNES	
29. SIGNATURE OF DECEASED JAMES A. BARNES		30. SIGNATURE OF WITNESS JAMES A. BARNES	
31. SIGNATURE OF DECEASED JAMES A. BARNES		32. SIGNATURE OF WITNESS JAMES A. BARNES	
33. SIGNATURE OF DECEASED JAMES A. BARNES		34. SIGNATURE OF WITNESS JAMES A. BARNES	
35. SIGNATURE OF DECEASED JAMES A. BARNES		36. SIGNATURE OF WITNESS JAMES A. BARNES	
37. SIGNATURE OF DECEASED JAMES A. BARNES		38. SIGNATURE OF WITNESS JAMES A. BARNES	
39. SIGNATURE OF DECEASED JAMES A. BARNES		40. SIGNATURE OF WITNESS JAMES A. BARNES	
41. SIGNATURE OF DECEASED JAMES A. BARNES		42. SIGNATURE OF WITNESS JAMES A. BARNES	
43. SIGNATURE OF DECEASED JAMES A. BARNES		44. SIGNATURE OF WITNESS JAMES A. BARNES	
45. SIGNATURE OF DECEASED JAMES A. BARNES		46. SIGNATURE OF WITNESS JAMES A. BARNES	
47. SIGNATURE OF DECEASED JAMES A. BARNES		48. SIGNATURE OF WITNESS JAMES A. BARNES	
49. SIGNATURE OF DECEASED JAMES A. BARNES		50. SIGNATURE OF WITNESS JAMES A. BARNES	
51. SIGNATURE OF DECEASED JAMES A. BARNES		52. SIGNATURE OF WITNESS JAMES A. BARNES	
53. SIGNATURE OF DECEASED JAMES A. BARNES		54. SIGNATURE OF WITNESS JAMES A. BARNES	
55. SIGNATURE OF DECEASED JAMES A. BARNES		56. SIGNATURE OF WITNESS JAMES A. BARNES	
57. SIGNATURE OF DECEASED JAMES A. BARNES		58. SIGNATURE OF WITNESS JAMES A. BARNES	
59. SIGNATURE OF DECEASED JAMES A. BARNES		60. SIGNATURE OF WITNESS JAMES A. BARNES	
61. SIGNATURE OF DECEASED JAMES A. BARNES		62. SIGNATURE OF WITNESS JAMES A. BARNES	
63. SIGNATURE OF DECEASED JAMES A. BARNES		64. SIGNATURE OF WITNESS JAMES A. BARNES	
65. SIGNATURE OF DECEASED JAMES A. BARNES		66. SIGNATURE OF WITNESS JAMES A. BARNES	
67. SIGNATURE OF DECEASED JAMES A. BARNES		68. SIGNATURE OF WITNESS JAMES A. BARNES	
69. SIGNATURE OF DECEASED JAMES A. BARNES		70. SIGNATURE OF WITNESS JAMES A. BARNES	
71. SIGNATURE OF DECEASED JAMES A. BARNES		72. SIGNATURE OF WITNESS JAMES A. BARNES	
73. SIGNATURE OF DECEASED JAMES A. BARNES		74. SIGNATURE OF WITNESS JAMES A. BARNES	
75. SIGNATURE OF DECEASED JAMES A. BARNES		76. SIGNATURE OF WITNESS JAMES A. BARNES	
77. SIGNATURE OF DECEASED JAMES A. BARNES		78. SIGNATURE OF WITNESS JAMES A. BARNES	
79. SIGNATURE OF DECEASED JAMES A. BARNES		80. SIGNATURE OF WITNESS JAMES A. BARNES	
81. SIGNATURE OF DECEASED JAMES A. BARNES		82. SIGNATURE OF WITNESS JAMES A. BARNES	
83. SIGNATURE OF DECEASED JAMES A. BARNES		84. SIGNATURE OF WITNESS JAMES A. BARNES	
85. SIGNATURE OF DECEASED JAMES A. BARNES		86. SIGNATURE OF WITNESS JAMES A. BARNES	
87. SIGNATURE OF DECEASED JAMES A. BARNES		88. SIGNATURE OF WITNESS JAMES A. BARNES	
89. SIGNATURE OF DECEASED JAMES A. BARNES		90. SIGNATURE OF WITNESS JAMES A. BARNES	
91. SIGNATURE OF DECEASED JAMES A. BARNES		92. SIGNATURE OF WITNESS JAMES A. BARNES	
93. SIGNATURE OF DECEASED JAMES A. BARNES		94. SIGNATURE OF WITNESS JAMES A. BARNES	
95. SIGNATURE OF DECEASED JAMES A. BARNES		96. SIGNATURE OF WITNESS JAMES A. BARNES	
97. SIGNATURE OF DECEASED JAMES A. BARNES		98. SIGNATURE OF WITNESS JAMES A. BARNES	
99. SIGNATURE OF DECEASED JAMES A. BARNES		100. SIGNATURE OF WITNESS JAMES A. BARNES	

CERTIFICATE OF DEATH

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